NECA IBEW LOCAL No. 364 HEALTH & WELFARE FUND

6525 Centurion Drive
Lansing, MI 48917
Telephone Number: 517-321-7502
(Mail original to this address)

Attention: Robin Perez
Local Union 364, IBEW
Facsimile Number: 815-398-1203
Telephone Number: 815-398-6282
(Fax copy to this fax number)

STATEMENT FOR LOSS OF TIME BENEFITS

(**Note: Participant must complete this portion**)

Name:		Date of Birth:	
Address:	City:	State:	Zip:
Member ID or SS#:		Local Union #:	
Is this claim based on an accident/injury?		Yes ☐	No ☐
Nature of sickness or accident/injury:			
Date sickness or accident/injury began:		Date first treated:	
Did sickness or accident/injury occur in the course of employment?		Yes ☐	No ☐
Where did sickness or accident/injury occur?			
How did sickness or accident/injury happen?			
Have you, or do you intend to file this claim under Workers' Compensation?		Yes ☐	No ☐
On what date did you last work?	Have you resumed work?	If yes, what date?	
Are you Retired?: Yes ☐ No ☐	Are you receiving Social Security Disability?: Yes ☐ No ☐		
Signature:		Date:	

ATTENDING PHYSICIAN'S STATEMENT

(**Note: Physician must complete this portion**)

Diagnosis and Concurrent Conditions: ICD9 Code:			
Is this claim based on an accident/injury?		Yes ☐	No ☐
Date sickness or accident/injury began:	**Date first treated**:		
Is condition due to injury or sickness arising out of patient's employment?		Yes ☐	No ☐
This patient has been continuously disabled from ____________ (first day unable to work) through ____________ (last day unable to work).			
Exact date patient will be able to return to work at trade:			
If exact date is unknown, please estimate:			
Is patient still under your care for this condition?		Yes ☐	No ☐
If YES, give date of last treatment:	When is next scheduled appointment:		
If NO, give date treatment terminated:			
Physician's Signature:		Date:	
Physician's Name (please print)		Degree:	
Address:			
City:	State:	Zip:	
Telephone Number:		Area Code:	